

Health Resources Division Rule Changes (Effective 7/1/14)

Health Resources Division Mega Rule: ARM 37.85.105

The department is amending ARM 37.85.105 to reflect a 2% increase in Medicaid fees to providers. This increase was appropriated by House Bill 2 of the sixty-third Montana Legislature. Updates were added regarding fee schedules, effective dates, conversion factors, percentages, and rates for services provided through the Health Resources Division. These services include inpatient hospital, outpatient hospital, physician, pharmacy and allied health services.

Overall Health Resources for Medicaid: Removal of the "By Report" Methodology

The rule amendments are necessary because CMS has mandated that the existing "By Report" or percentage of billed charges language and methodology be replaced with a set fee and an established methodology of how those fees are calculated.

Hospital Inpatient

Elective Deliveries: ARM 37.86.2801, 37.86.2806, 37.86.2901, 27.86.2902, 37.86.3001

Elective inductions, cesarean sections, and early deliveries all increase the risks to both mother and infant, and there is no evidence that they confer any health benefits in the absence of medical necessity. These deliveries also increase the average hospital stay and costs for both mother and infant. Montana Medicaid, as the payer of more than one-third of the births in Montana, is in a key position to contribute to the reduction of elective early deliveries. The policy will be implemented in three steps:

July 1, 2014, all facilities enrolled in Montana Medicaid who perform deliveries must have a "hard stop" elective delivery policy in place. The policy requires specific guidelines be met prior to any induction or cesarean section.

July 1, 2014, the department will begin a soft rollout of required coding changes, allowing the department to provide information and support to those providers who are not in compliance with the guidelines. Coding changes must be implemented no later than October 1, 2014.

October 1, 2014, a reimbursement reduction of 33% for facilities on all claims that are submitted that are determined by the department to be an elective delivery.

Outpatient Cardiac/Pulmonary Rehabilitation Services: ARM 37.86.3101, 37.86.3103, 37.86.3105

The department is amending outpatient cardiac/pulmonary rehabilitation services. The changes to these rules are necessary to comply with the Centers for Medicare and Medicaid Services (CMS) guidelines for these services. The previous guidelines required that all treatments be completed within eight weeks for cardiac rehab, and six weeks for pulmonary rehab. These timelines have been removed and both now allow 36 sessions with a maximum of two 1-hour sessions per day. The previous guidelines also allowed for multiple different diagnoses for pulmonary rehab; CMS has updated this to just moderate to severe chronic obstructive pulmonary disease.

Upper Payment Limit and Methodology for Collection of Any Overages: ARM 37.86.2820, 37.86.2901, 37.86.3001

The department is amending to add language pertaining to the methodology for collecting overpayments when the upper payment limit is exceeded. The upper payment limit is a limit put in place through federal regulation. The department currently does not have language in rule defining how overpayments will be collected.

Obstetric Observation: ARM 37.86.3020

The department is amending inpatient services regarding obstetric observation. The current language in regarding obstetric observation qualifying diagnosis-related groups has been updated to new numbers since the original completion of this rule. The descriptions of these diagnosis-related groups have not been changed. The related number is the only item that changed.

Provider-Based Entity: ARM 37.86.3001

The department is amending outpatient services regarding provider-based entities. "Provider-based entity" is defined in ARM 37.86.3001 in (17), and a provider-based professional is defined in (19). The department is proposing to combine these two definitions into one as together they are a full definition of a provider-based entity.

Emergency Room Visit Reimbursement: 37.86.3009

The department is amending outpatient services regarding emergency room reimbursement. The department is proposing to remove the term "lowest level." As of January 1, 2014 the department has

gone to a single level facility Ambulatory Payment Classification (APC) weight; therefore, there is no longer a lowest level APC weight.

Dialysis Clinic Program: ARM 37.86.4205

The department is proposing to pay dialysis claims at the Medicare composite rate as instructed by the Centers for Medicare and Medicaid Services (CMS). This change will meet the upper payment limit requirement set forth and proposed by CMS.

Clinic Services: Ambulatory Surgical Centers: ARM 37.86.1406

The Centers for Medicare and Medicaid Services (CMS) will no longer allow reimbursement using the ‘by-report’ or ‘usual and customary’ methodology. By-report and usual and customary language means paying a percentage of billed charges. The department is proposing to remove ‘usual and customary’ reimbursement language and replace it with ‘payment to charge’ reimbursement methodology which is approved by CMS.

Birth Attendant: ARM 37.86.1201

The department is proposing to incorporate current procedural terminology (CPT) and the provider manual into the birth attendant rule.

Lab and X-ray Services: ARM 37.86.3201

The department is proposing to move laboratory and x-ray reimbursement language from the RBRVS rule to the laboratory and x-ray rule.

Plan First: ARM 37.82.701

The department is proposing to update Plan First eligibility from 200% to 211% of FPL and remove the language prohibiting women with insurance or health coverage from being eligible.

HMK Program Coverage: ARM 37.79.102, 37.79.304

The department is proposing to amend this rule to reduce the administrative burden on providers and staff and to streamline needed dental services for HMK members. The change will:

- Increase the Healthy Montana Kids Basic Dental Benefit to \$1900 while eliminating the HMK Extended Dental Benefit.

- Additionally the effective date of the Evidence of Coverage must be changed to incorporate these changes effective July 1, 2014.
- The department is proposing to amend the definitions for "Benefit Year" by adding "Benefit Year" for medical and mental health and a new paragraph for dental to this definitions rule. The benefit period for dental is July 1st through June 30th. If the member's effective date is after July 1st, the dental benefit period begins with the member's effective date and ends on June 30th.

Medicaid Prescription Drug: ARM 37.86.110

The department is proposing to amend this rule based on a 2013 legislative audit. This audit found that there were insufficient procedures in place to investigate and track member fraud and abuse. Since this audit, internal processes have been strengthened and refined in regards to member fraud and abuse.

New Rule I allows providers to report cash payment in reporting suspected fraud, abuse, or both. This is necessary because the recent amendment to the Health Insurance Portability and Accountability Act (HIPAA) prevents providers from reporting cash payment to health plans if requested by a member unless there are regulations in place that allow it. In addition, the rule will explicitly state department policy on early refills and lost or stolen medication. In addition, the rule includes the following policies:

- a link to the Board of Pharmacy's rule on Tamper Resistant Pads; a link to 42 CFR Part 455, Prescription Fraud and Abuse;
- a description of the department's policy on early refills for both controlled and non-controlled substances;
- a description of the department's policy on lost or stolen medication.

Rule Changes Effective October 1, 2014

Early Induction Physician: The department will be proposing amendments to physician and mid-level practitioner rules pertaining to early elective inductions and cesarean sections, and non-medically necessary cesarean sections.

The department will begin a soft rollout of required coding changes, allowing the department to provide information and support to those physicians and mid-level practitioners who are not in compliance with

the guidelines. Coding changes will be implemented October 1, 2014 and a reimbursement reduction of 12% will be applied.

The department is also proposing amendment to a general Medicaid rule at ARM 37.85.406 to clarify provider requirements when performing services in a facility where services are arranged by a facility but the provider is not enrolled with Montana Medicaid.